REPORT

of

Investigation into the Operation

of the

British Health Insurance Act

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in company with

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FOR THE

PENNSYLVANIA HEALTH INSURANCE COMMISSION
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Preface

IN submitting this report, the undersigned desire to call attention to two facts: (1) the field inquiry consumed only one month, July, 1920; (2) the method of inquiry was therefore necessarily confined to reading all available documents and to the interviewing of over fifty representative persons in London, Manchester and elsewhere, including government officials, employers, union officials, friendly society officers, commercial insurance company officials, insured workers and doctors.

The Chairman of your Commission was accompanied to England by Mr. Ordway Tead, a professional consultant in labor problems, who was retained to do the specialized work involved in such an investigation, and to formulate the findings. Since at practically every interview both of us were present, not only did we have the advantage which comes when two people are seeking the facts instead of one, but the observations and conclusions here set forth are those of both the Chairman and the investigator. It was the easier for this agreement to be reached because the outstanding facts about the English situation soon become apparent to any honest and unbiased observer.

The study in England was prefaced by as full a reading knowledge as possible of the details of the health insurance legislation, although this had resulted in no settled conviction as to the working of the act. The inquiry was conducted with thoroughly open minds, without preconceptions, with a sincere desire to get the whole truth.

Moreover, special pains were taken before leaving this country to communicate with prominent individuals known to be deeply interested in health insurance either because of their advocacy or their opposition. Letters of introduction were obtained equally from both groups and the special effort throughout our visit was to search out and interview those in England who were opposed to the act. It may be said in passing that the active opponents to it are very few, and many, if not most, of the persons whom it was suggested that we see by those on this side of the water known to

be most critical of health insurance, turned out to be in general favorable to health insurance and only critical of the present act in some of its details.

In short, no step was omitted that would assure our hearing all the adverse things that could possibly be said by well-informed English subjects about the working of the act.

The result may be unsatisfactory to those who desire unqualified statements of approval or disapproval. For the conclusions reached in this inquiry are not unqualified. They indicate a degree of success and a degree of what is less failure than confusion of purpose, which has necessarily resulted in gradual but important changes in the insurance act and in the other public health legislation as well.

This kind of a qualified conclusion will be seen to be inevitable by all who realize that social institutions develop experimentally. The value of this investigation for America is thus the greater because England's experiments need not be repeated in every particular. They can and should be used as the basis for wiser measures designed specifically to meet American conditions and needs.

September 15, 1920.

William T. Ramsey,
Chairman of the Commission.

Ordway Tead,
Expert Investigator.

I. Introduction

1. Summarized Conclusions

THE investigation into the operation of Health Insurance in Great Britain which was undertaken at the request of your Commission, was designed to find the degree of success attending the operation of the present act, to discover the attitude of the various affected groups toward it, and to consider as far as possible the extent to which it might be applicable to American conditions.

It may be said at once that in the main and considering the handicaps and obstructions suffered during five years of war the act is in reasonably successful operation and is beginning to produce some of the benefits that were initially urged in its behalf.

In the second place the affected groups in the community are now working the act with a remarkable degree of co-operation and with an all but universal recognition of the value of the legislation. Few in the community would seriously advocate or even contemplate its repeal or withdrawal. The tendency and common desire is in quite the opposite directions to make the act in fact as well as in name a **national** act which will really **assure** good health throughout the country.

In the third place, as this report will presently develop, it is highly probable that much may be learned from the failures and the shortcomings of the present operation; and any rigid copying of the British act would certainly be quite unwarranted when the peculiar conditions under which it has developed are understood.

Points at which the British experience can most certainly provide a useful warning are the following:

1. The cash benefits should not be paid through approved societies but through local bodies publicly constituted.

2. The cash benefit should be at least 50 per cent of wages.

3. The medical benefits should not be limited to the insured workers, but should extend to their families.

4. Hospital care, consultant services and specialized diagnostic facilities in the form of clinics and laboratories should not be left out of the plan, but should be incorporated as part of the medical benefit.

This report will amplify and explain the above statements. It will be exceedingly difficult to offer anything like statistical proof

of them because to a considerable extent that does not exist. At every turn and in respect to every problem we were repeatedly told "You know, during the war it was impossible to do that, etc.," or, "The experience of the war years would really vitiate any figures we might offer." Hence, while we have sought figures wherever possible, we have even more sought the considered opinions of representative and typical spokesmen of the government's administrative staff, employers, trade unions, approved societies, panel and general doctors and insured workers.

2. Purpose of the Act

It is first necessary to consider what the act was intended to do. It was advanced by Mr. Lloyd George in 1911 to some extent for political reasons, and also to meet the conditions revealed in the reports of 1909 Poor Law Commission. It was originally intended to carry insurance against sickness and death to workers and their dependents through state organized funds. But because of the strength of the commercial life insurance companies and of the "friendly societies" (working-class mutual benefit societies) the death feature was omitted and these organizations were allowed to become the agents for administering the cash benefits. And because of the work and expense involved the dependents were excluded (except in the case of the maternity benefit for the wife of the insured man).

The act was designed to be a preventive of ill health and a means of alleviating the destitution which it brought. If "prevention" is taken to mean discovering from the records of sickness its incidence in particular trades and local areas, with special study and treatment to reduce that incidence where it is excessive, little has been done. But if prevention means also making it easy for all working people between 16 and 70 to consult a doctor as soon as they begin to feel ill or whenever they are too ill to go to work and therefore want to be certificated for cash benefits by their doctors who must consequently examine them, then the amount of preventive work has been tremendous. **Hundreds of thousands of persons, it is universally agreed, seek medical advice now who would not have afforded it before; and they seek it promptly. They seek it, as the doctors told us, at a stage when the length and seriousness of the illness can usually be reduced.** The fact that there are roughly twice as many visits paid by doctors now as there were

before the act was in force may be taken to prove not that there is twice as much illness or unnecessary visitation, but that people see the doctors as soon as they feel indisposed, and that many people now secure medical attention who never got it prior to the act. As a doctor put it to us, "If three men come to me two of whom have little or nothing the matter with them, and the third is in the early stages of some serious disease, all three visitations are justified."

As to the other purpose of the act, the relieving by cash benefits of destitution due to sickness of the wage-earner—the situation has been so profoundly changed by the war that accurate statements are difficult. The cash benefit, even as increased by recent legislation, is so small as compared with wages that in cases of prolonged sickness the need of some larger degree of outside assistance is still necessary. The act does not provide a large enough cash benefit to remove the possibility of destitution resulting from the wage-earner's sickness. Due to a combination of causes, however, the amount of actual destitution is less in England (July, 1920) than before in recent years. It is, for example, generally admitted that wages have in most cases risen to a degree that has made provision out of wages for more food and for illness more likely than in pre-war days. Especially have the unskilled workers improved their status in this respect.

II. Brief Description of the Act

THE original act of 1911 was amended at various points in 1913, 1918 and 1920. Since the report of the previous Health Insurance Commission of Pennsylvania[1] contains an admirable outline and summary of the provisions of the basic legislation, it is only necessary to mention below the essential features of the present law and regulations. Many minor provisions have intentionally been omitted in the interest of clarifying the main points.

1. Contributions

Men pay 10 pence (20 cents) a week, of which the employer pays 5 pence and the worker 5 pence. To the amounts thus collected the state adds an amount equal to 2/9 (two-ninths) of the total.

[1] Report of the Health Insurance Commission of Pennsylvania, January, 1919.

Women pay 9 pence (18 cents) a week of which employer pays 5 pence and the worker 4 pence. To the amount thus collected the state adds an amount equal to ¼ (one-fourth) of it.

These contributions are payable in respect to practically all manual workers, and all non-manual workers whose income falls below £250 per year ($1,250).

Other citizens may join as "voluntary contributors," but since no medical benefits are available for them they pay a reduced contribution.

The contributions are made through the employer who buys special stamps at the post office. These he is required to affix weekly to the card of each employee as in evidence of payment.

If the employer has more than 100 employees he may stamp the worker's card half yearly with one lump sum, high-value stamp representing the total amount of the combined contributions. These cards are at each six months' interval given to the individual workers who send them to their respective "approved societies" (presently defined) which in turn use them as evidence of payment to get the proper funds credited to them by the Government. The approved societies then distribute fresh cards to the employers with whom their members are at work.

2. Cash Benefits

The man who is certificated by the doctor as "incapable of work" because of some specific illness is entitled to 15 shillings ($3.75) a week after a three-day waiting period, which payment may continue for twenty-six weeks. And for continued disability thereafter he gets 7 shillings 6 pence ($1.88) a week so long as he is incapable of work.

The benefit for a woman worker is 12 shillings ($3.00) with the same disability benefit as the man's.

To be eligible for these benefits the worker must have paid contributions for 26 weeks; and he is deemed to be in arrears in his contributions if they are not made for at least 48 weeks in the insurance year. When in arrears the worker is notified and has three months' grace in which to become fully eligible by the payment of a fixed sum depending upon the length of the arrears period; and if that is not paid he is eligible for benefits at a lowered rate.

A married woman worker is entitled to 40 shillings ($10) at confinement. The wife of an insured man is entitled in her own right to the same amount when confined; and if both husband and wife are working, two maternity benefits are paid.

The cash benefits are usually paid through the local officer of an approved society upon presentation to the society of the medical certificate from the worker's doctor and also in many cases after a visit from the society's sick visitor.

3. Medical Benefits

Every insured person is entitled to medical attendance throughout his illness provided it is service that can be rendered by a general practitioner of ordinary skill and capacity. This service does not, however, include the services of a doctor at times of confinement of an insured woman or of the wife of an insured.

The sanitarium benefit heretofore providing hospital care for tuberculous insured persons, is to be withdrawn after 1920 for reasons which will be presently considered.

Medical benefit also includes the free provision of the familiar drugs and medicines and of a stated number of medical and surgical appliances such as bandages, etc.

There is **no** statutory provision for hospital treatment, nurses, dental treatment, medical attendance upon the dependents of the insured, specialists' advice or medical care at confinement.

4. Administration of Cash Benefits

There are the following general types of carrying funds which the insured person may join:

An approved commercial insurance company.
An approved friendly society.
An approved trade union.
An approved establishment fund.

In addition, there is a class called deposit contributors, who belong to no society, but hold their own cards and buy stamps for themselves at the post office. Their contributions are only available in benefits to the amount of their own and their employers' payments; there is no sharing of the risk with the members of any group.

The worker has the option of choosing his approved society; and he may not transfer except at stated intervals and on payment of two shillings.

The approved societies are not profit-making bodies and they do not pool their funds. Each fund is supposed to carry its own burden of sickness and the idea has been that if any society accumulated a surplus, that value would be available for larger benefits

to the members of that society. A valuation was to be made every five years to determine the condition of the funds; but owing to the war the first valuation is only now being brought to completion. The results of it will not be published until early in 1921; but they will probably show a considerable variation in surpluses.[2]

5. Administration of Medical Benefits

The local doctors who desire to practice under the act—that is, do the medical work for the insured—are contracted with by a local insurance committee, which is the representative administrative and supervisory body of each local area in respect to the medical side of the act. Doctors are now paid at the rate of 11 shillings per year per person on their "panel." However, in Manchester and Salford, although the total sum of money available to be used in payment of the local doctors is allotted at this rate, the individual doctor is paid on a visitation basis on a scale locally agreed upon.

Complaints of inadequate or unsatisfactory medical service are supposed to be brought to this insurance committee; and if there is a real case against a doctor there is an investigation and final decision by a body of inquiry composed of three doctors and a barrister.

Up until now if there has been doubt about the certification by a doctor of an insured person, the approved society has usually employed its own medical referee to give an opinion. Under the latest amendment thirty state referees have now been appointed to look into doubtful cases.

In order to assure a reasonable division of work and proper service to each individual, the size of the panels is now to be limited to a maximum of 3,000 persons, with authority in the local insurance committee to restrict the number further where they so desire. In the London area, for example, the panel of any individual doctor may now be only 2,000. In Manchester, on the other hand, it may be 3,000. As a matter of fact the great majority of panels are less than 2,000 in number.

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[2] Interim Report by the Government Actuary upon the Valuation of the Assets and Liabilities of Approved Societies as of December, 1918.

6. Financial Arrangements

The explicitly recognized expenses under the act are the following:

1. The cash benefits.
2. Payment to doctors at the rate of 11 shillings per person per year.
3. Administration expenses of approved societies at rate of 4 shillings 5 pence per person per year.
4. Administrative expenses of insurance committees.
5. Payment for drugs on basis of an agreed schedule of prices.
6. Administrative expenses of Ministry of Health including indoor and outdoor staff.
7. Reserve Fund.
8. The contingencies fund.
9. Women's Equalization Fund.
10. Central Fund.

(The last four funds are explained later.)

To meet these expenses there are available the three-fold contributions, and sundry parliamentary grants which have been called for as special problems have arisen.

7. National Administration

The central administration which includes allocation and handling of accounts, inspection of operation of the act by employers, insurance committees and approved societies, issuance of regulations, stamps, cards, etc., is vested in a department of the Ministry of Health.

The actual arrangements with local doctors and the actual payment of cash benefits is, however, left to the several local agencies above described.

III. Other Public Health Legislation

NO adequate picture of the working of the act is possible without mention of the public health measures which are simultaneously provided.

In 1919 the Ministry of Health was organized "for the purpose of promoting the health of the people" of Great Britain. Under it are now grouped **for purposes of co-ordination** the following administrative duties:

1. Those of Local Government Boards pertaining to Public Health.
2. The administration of the National Health Insurance.

3. Supervision of work of Board of Education for expectant and nursing mothers and of children up to five.

4. Supervision of work of same body in respect to medical inspection and treatment of school children.

5. Supervision of midwives.

Under other recent enactments, provision is already made by most local authorities with the aid of special grants from Parliament for treatment of tuberculosis, venereal diseases, medical and dental work for school children, maternity and infant welfare centers.

The situation is well summarized in the following paragraph:

"(1) Before birth the expectant mother may be dealt with by the local Health Authority (*i.e.*, the Town or County Council, or District Committee), under the Notification of Births (Extension) Act (Child Welfare).

"(2) At birth there may be in attendance either a midwife provided by the Local Authority or a panel, or private medical practitioner.

"(3) From birth till five years of age is reached, the child again comes under the Child Welfare Scheme of the Local Authority.

"(4) Between five and fourteen years, the child comes under the medical inspection scheme of the Education Authority, but if treatment is required that may be obtained from the family doctor or through a voluntary or charitable agency, or through clinics provided by the Education Authority.

"(5) From fourteen to sixteen years there is no public provision of any kind for medical treatment, but the young person, if seeking employment in a factory, will be examined by a certifying Surgeon appointed by the Home Office.

"(6) From sixteen years of age till the end of life, the man or woman, if employed, comes under the Insurance Acts, and receives Medical Benefit through the Insurance Committee."[3]

The doctors engaged on full or part time under one or another of these provisions probably total several thousand, and are thus in fact the members of an embryonic national medical service.

In addition to the above provisions it should be explained that the Local Poor Law Guardians also have their own medical and hospital provisions for destitute persons of any age. But it is now proposed and contemplated that all of this work shall be taken over and done under the local authorities, which will mean the final abolition of the Poor Law administration in so far as it constitutes a distinct branch of the medical service.

It is significant to point out in connection with all of this legislation that the tendency is definitely toward **separating from the insurance act all special medical treatment** and toward

[3] A Public Medical Service, by McKail & Jones, 1919.

providing on a universal public health basis those medical services which are not readily available through a general practitioner. This is the meaning of the removal of tuberculosis and venereal disease treatment from under the act; and of the institution of maternity centers and care for all mothers under an act of 1918. And it is not unlikely that in the next few months the Government will bring in a bill on the hospital question which will at least provide state payment for insured persons in hospitals and possibly for all regardless of whether they are or are not insured.

In short, the insurance act has been one of the potent influences in rallying public attention and support to a consistent and complete program of public health administration. And the Ministry of Health will undoubtedly in the next few years extend the scope and improve the quality of the medical services available for all the people. To this extent the insurance act has unquestionably been an aid in the direction of fundamental preventive medicine.

Having given this brief sketch of the framework of health insurance legislation and administration, it is necessary next to consider its actual operation.

IV. The Act in Operation

1. Contributions

AT present there is little if any objection to be found to the compulsory collection of contributions, except from those who believe that the contributory principle is less sound or less economical than the non-contributory—believe, namely, that cash subventions as well as medical service should be provided directly out of taxes.

It appears to be widely understood that in whatever way immediate expenses are met, it is ultimately industry itself from which the cost is met. Whether the contributions are direct by assessment or indirect from taxation, the income out of which payment comes results from the productivity of industry and agriculture. And it is not generally felt to be a matter of primary moment to argue

whether the contributions at least for the medical service should be secured in one way or another.[4]

On the other hand, it is true that the present contributory method of collecting the funds out of which the cash benefits and the medical benefits are paid, lightens the burden of direct taxation and is not felt to be an onerous burden by any individual employer or worker. From the point of view of adjusting the Government's public health budget to its available income resources, this consideration becomes, of course, of almost determining importance. It should be clear, however, that if we in the United States elect to proceed by the contributory plan or by public grants, there is some substantial expense involved. Good health can be bought only and as soon as we are willing to pay the price.

As to the administration for collecting the benefits, the work and confusion are now reduced to a minimum. Yet it is useful to consider further (1) the method of collection and (2) the cost of collection.

If the contributory idea is to prevail, there must of course be some definite evidence of payment which is readily available for the employer, the insured, the approved society and the government. The stamped card was only adopted after the most prolonged consideration; it is admitted to be a clumsy method, but no satisfactory substitute has yet been found which will apply to all cases. It is still conceivable, nevertheless, that a simpler method might be used for all but the most irregular and shifting types of work where, because the worker is constantly moving about, it is hard for him to have at all times evidence of his standing as to payment.

The method of lump-sum stamping at the end of each six months obviates much clerical work. The machinery of collection may thus be said to be running as smoothly as could be expected in a huge system comprehending 15,000,000 people and ranging from scrubwomen who come in by the day to highly skilled artisans and clerks whose income is regular.

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[4] A valid criticism may be made, however, against the restriction of the benefits to a limited number. Sir Arthur Newsholme, Medical Officer of the Local Government Board, says, for example, in a recent volume (*Public Health and Insurance*, Johns Hopkins Press, 1920): "On the point of equity it must be admitted that any system of so-called insurance which, like that of the English act, excludes a large proportion of the population who, while paying in taxes in aid of the insured, require but do not receive their benefits, is contrary to the principle that any expenditure of Government funds should ensure to the whole commmunity in need of the provision in question."

Nevertheless, thoughtful administrators of the act, including such persons as approved society secretaries, government inspectors, the best doctors, etc., call the whole stamp machinery into question —at least so far as the contributions are made to affect eligibility for medical attention. They point to the difficulties created by loss of cards by workers, agents or approved societies, by failure to stamp cards, failure to pay arrears. They point to the large amount of time and money required to hunt down (1) the loss or error in one card, (2) to be sure that employers are regularly stamping the cards, (3) to be sure that workers are technically eligible for benefits to which they are entitled or which they manifestly should have. In the Government's own inspecting staff an enormous amount of time is certainly spent straightening out irregularities in regard to contributions.

The cost of contributions and collection is negligible as far as the individual employer is concerned. The administrative expense of bookkeeping entries and stamping is surprisingly small; and the employer's share of the contributions is usually not over one per cent of the payroll. For example, in one store with over 7,000 employees not more than the equivalent of the full time of two clerks is devoted to the health insurance details. In one factory with about 800 workers about half the time of one clerk was used. In general this cost would come to not over one-tenth of one per cent of the payroll. The testimony of employers was therefore unanimous that the expense of the act to them was not a factor of any importance.

From the public point of view, however, the total expense of securing the contributions is undoubtedly great when all items in the account are considered—inspection, printing, postage, handling of stamps and cards by employers, approved societies and government officers. And that irregularities regarding contributions and stamping should ever deprive the insured of medical treatment is surely a denial of the whole idea of assuring good health among the workers. It frequently happens, moreover, that the worker whose contributions are not in good order, will be the very one who needs most not only the medical but the cash benefit as well.

In short, the conditions determining the eligibility for cash benefits may also disqualify the worker from benefits on the medical side. **This inter-relation seems to have little to commend it from the public health point of view.** There should, it would seem, be no question **from the public health point of view**

of eligibility for medical benefit. **Any person needing medical attention should be able to have it.**

2. Cash Benefits

The cash benefits, even as now increased, is in most cases such a small fraction of the possible wages that it is decidedly inadequate to protect the income and living standard of the insured during illness. It is generally conceded that the benefit should be less than wages, but a cash benefit which is 50% of wages is the very least that should be considered if a real subsidy is intended. Yet with a wage level for men workers today of between three and a half and five pounds a week (from $17.50 to $25.00), the weekly cash benefit of $3.75 is less than 25 per cent of wages.

The small size of the present cash benefit not only automatically brings malingering to a minimum, but, as several doctors said, the sick worker often returns to work before he should. Even unskilled workers are in many cases able to earn as much in one or two days' work per week as they could get from the whole week's benefit. The problem from the point of view of malingering only becomes difficult in cases of irregular work, where the worker may not have regular weekly employment and thus may normally get wages which do not exceed the usual benefit.

The promptness with which cash benefits are paid appears to vary greatly with the efficiency of the approved society. The best organized societies unquestionably pay claims promptly upon their receipt. Delay may be due to many causes, principal among which are the question in the mind of the society as to the validity of the medical certification, and (in the case of commercial companies) transfer of agents with whom the insured thus gets out of touch and therefore does not know where to submit his claim.

The cash maternity benefit is undoubtedly the most popular and the most valued. The money is now paid directly to the woman beneficiary and the testimony is general that in ninety-five cases out of a hundred, the money is used to help in defraying the expenses of confinement. It assures that the mother takes care to have a qualified midwife in attendance at the confinement. And the latter is sure to be on hand since she knows that the money for her fees is available. Moreover, the midwife is now required in case of any complication to call in a doctor whose attendance fees are paid by the local authorities under the maternity provisions legislation of 1918. Indeed, now that there is in most local areas some

follow-up work with expectant mothers (as a Public Health Provision), the likelihood is even greater that the maternity benefit will be wisely expended.

The maternity benefit is not, however, adequate to cover all the charges incident to confinement. The nurse's or doctor's fees usually take all or nearly all of the benefit, which leaves the other expense to be otherwise met. There is therefore a demand, especially in labor circles, for the payment of a larger amount which will be more in the nature of a maternity endowment paid to all mothers.

There is also on the part of organized labor a definite sentiment favoring the addition of a funeral benefit for the deceased worker. The demand for this will undoubtedly be strengthened by the recent governmental inquiry into the operation of commercial insurance companies, which found that in one large company over 40 per cent of the insurance policies lapsed with consequent advantage to the companies and no return whatsoever to the insured; and found also that " though practically every person in the wage-earning class is insured at some point of his life, at least 30 per cent of the deaths among that class are uninsured at death."[5]

Indeed the departmental committee of inquiry intimated that " it might be practicable to propose a funeral benefit to be administered under the National Health Insurance System."

3. Medical Benefits

As already suggested, the existence of free medical service for all insured persons means that many now go to doctors who did not do so before and go at the earliest signs of illness. Everyone agrees that this is an incalculable benefit, the good results of which in a better level of health cannot fail to materialize.

It should be pointed out, however, that the medical service which is available is neither thorough nor exhaustive; nor is it expected to be under the terms of the act. If a doctor finds that a case requires an operation, or he is uncertain of the proper diagnosis, he must now have recourse to hospital and consultants **whose services are not required to be available to him or to the insured under the act.** It has happened fortunately up until now that the voluntary hospitals (supported by private subscription and by the free work of their medical staffs) have stood ready to supplement the work of the general practitioner

[5] Industrial Insurance Companies and Collecting Societies, Cd. 614, 1920.

to the extent of their facilities. In this way, hospital service has been usually available, although it has never been guaranteed, never been completely adequate in the urban districts, always been dependent on private charity and subject in no way to any control by the patients or by the public health authorities. It is one of the anomalies of the act that **its success on the medical side depends upon access to hospital and consulting facilities which have as yet no organic relation to the rest of the scheme.**

Now that the hospitals are on the verge of insolvency, the Government is being obliged to consider relating them to the insurance provisions more formally.

Much attention was given in our investigation to the quality of medical service given. While accurate general statements are difficult to make, it is probably fair to say that the workers of England are on the whole now getting more and better medical service than they ever did before the act. It has to be remembered, however, (1) that under the act **every registered general practitioner has always been eligible to become an insurance doctor, simply by making application**; (2) during the war a great many of the best practitioners were in army or navy service; (3) the act only requires such treatment as "can consistently with the best interests of the patient, be properly undertaken by a practitioner of ordinary professional competence and skill." (Medical Regulations.)

These three facts alone go far to account for much of the criticism which has been leveled at the quality of medical work given under the act. Moreover, the doctors were at first hostile to or suspicious of the act. Today this is not true. Out of between 20,000 and 23,000 doctors (how many of these are only consultants and not supposed to do insurance work is difficult to find out) who are in active practice, over 14,000 are on the panels.

Criticism of the medical service has fastened on the danger of "lightning diagnosis;" on the distinction made in attention given to panel as against non-panel patients; on the difficulty of lodging complaint against a doctor; and on the fact that the best doctors do not become insurance practitioners. There is undoubtedly considerable basis for some of these criticisms or they would not be repeated so often. But the testimony is on the other hand convincing that medical service is better now, barring the handicaps of war just noted, than it ever could have been before for thousands of persons. Now that the number of patients per insurance doctor is to be limited and the doctors are finding their panel practice in

most cases so remunerative, the reasons for inferior service will be reduced. The doctors are and will be increasingly anxious to keep the good will of the insured and of the insurance committee as well.

The Scotch Health Insurance Commission which until July, 1919, administered the act for Scotland says in its latest report that " very little reliable evidence has emerged of neglect of duty on the part of insurance practitioners or of any real ground for loose general charges of inefficiency. Dissatisfaction with a limited service and agitation for an extended and complete medical and institutional service **must not be founded on as a condemnation of the present insurance scheme but rather as an indication that it has resulted in increased appreciation of the importance of a great development of medical services in the interests of the national welfare.**" (Boldface ours.)

Invidious distinction between panel and non-panel patients is undoubtedly still made; but it is generally considered to be decreasing. The **feeling** of inadequacy in the attention received appears to be a social as much as a medical matter. In those cases where the insured person does not use his panel doctor, but goes to another physician and pays a private fee, the person is usually in the ranks of the clerical workers who still feel a certain class superiority to manual workers and therefore to panel doctors who treat manual workers.

The real reason for inadequacy of treatment is affirmed by the best doctors in England to be due rather to inadequate medical education and insufficient opportunity for special diagnostic assistance from which insured and non-insured suffer alike. Opportunities for study after the doctor leaves medical school are meager; his opportunities for consultation with other practitioners and specialists are not well organized; access to laboratories is not assured.

An offset to this as well as to other shortcomings of general practitioners' service, is increasingly being resorted to in the form of partnerships of insurance doctors. These partnerships are of from two to six men, each of whom has his assigned hours at the offices and also naturally has some diseases on which he is more of a specialist than his colleagues. Under this arrangement the insured are certain of a doctor being at hand all the time, yet each individual doctor has free time for study and recreation. The terms under which these partnerships work are governed by regulations of the Ministry of Health, so that the danger of any abuse of the

plan is slight. Indeed, such arrangements appear to be officially encouraged. Similar results are to a certain extent obtainable where an insurance doctor hires an assistant to help him.

The medical services under the act are, it should be emphasized, specifically planned on the theory that only general practitioners' services can at this stage be given. Tuberculosis care, for example, except for domiciliary treatment, is now removed from the act and entrusted to the local authorities. The insurance doctor is not supposed to have to treat venereal cases, which also go to a local clinic. Nor is the insurance doctor expected to take maternity cases unless he so elects. But he is supposed to be able to diagnose and treat the usual complaints and to act as a clearing house for sending special cases to the necessary agency. It is in his home contacts and constant knowledge of the family that his value lies. The policy thus exemplified seems to argue for more adequate statutory provisions to correlate general and specialist advice.

The question of determining eligibility for medical benefit reveals the anomaly of trying to adhere strictly to the insurance principle in the provision of medical treatment while at the same time trying to make the physicians' services as fully available to all as possible. Loss of one's medical card, failure to pay a sufficient number of weeks' contribution or failure to "sign on" to a doctor's list, may temporarily make it difficult if not impossible for one to be eligible for medical attention. Testimony is general, however, that a person needing treatment is likely to get it regardless of his legal status under the act. And this seems natural. **The only real evidence which it should be necessary to give as to eligibility for treatment is increasingly seen to be the need of treatment.**

This principle does not apply as yet, however, in the case of attention needed by the dependents of the insured. They must pay for their service; and, as would be expected, the workers of a family go to the doctor on the slightest provocation, while the non-insured persons will wait until illness becomes serious and therefore doubly difficult to cure. Yet even here the tendency is for the insurance doctor in his home visits to consider the troubles of other members of the family in which situation the fee, while important, is not the primary consideration. And without a great deal of bother the visiting insurance doctor can often direct a non-insured sick person to the service of local doctors available under special provisions for the tubercular, for maternity cases, school children's cases, etc.

Decision as to the eligibility of the insured for benefits in doubtful cases is now in an unsatisfactory state, since the standards of different approved societies vary so greatly and their method of local follow-up are so different. As it is, if the approved society doubts the validity of a claim it usually sends its own doctor or referee to see the patient, advising the local doctor of the step and asking for his help. This intervention is usually welcomed and the necessity for a second diagnosis is so far recognized by all that thirty referees are now included as salaried doctors under the act. Indeed, it is not inconceivable that the time may come when there will be one doctor to give medical advice and a wholly different one to authorize the certification for cash benefits. It is felt by many that there is much to commend such a separation of two quite different functions.

It is in fact difficult to tell in many cases whether incapacity for work really exists. The border line cases are many, especially where there is a tendency to diagnose illness as "general debility" and "anemia." In such cases it will be seen that there are two points of view at work and they perhaps form a wholesome corrective to each other. There is the point of view of the approved society anxious to suspend payments as soon as that can be justified; and there is the point of view of the insurance doctor who usually sees the need, especially with "run down" persons, of a prolonged rest without worry and under wholesome conditions. It is admittedly hard to reconcile these points of view where the surrounding conditions, economic and otherwise, are constantly working to negative the efforts of the doctor. Truly preventive work in many cases requires more than cash or medical benefits. It requires more food and better-cooked food, more fresh air, more quiet, no worry, etc. Failing these, cash benefits and bottles of medicine or tonic may be poured out unceasingly without appreciable results.

It should be noted, in short, that under any act it will be difficult in certain cases to define when the person is sick; and it will be necessary while giving medical service without stint to use care in paying cash benefits for these border-line instances of incapacity or valetudinarianism.

This is, of course, an aspect of the problems of malingering. There is undoubtedly some of this kind of unconscious malingering which has to be guarded against; and the use of referees under the act is essential to keep this at a minimum. It is also necessary to this end to have the administration of cash benefits

in the hands of a local agency which can really be in intimate touch with the beneficiaries.

At present there is the further safeguard of weekly certification for cash benefits by the doctors (except in chronic cases where the approved society agrees to accept a bi-weekly or monthly certification).

Apart from these comparatively exceptional border-line cases, the amount of deliberate malingering is agreed by all to be negligible. Indeed, as a problem of practical administration, it has hardly to be reckoned with.

4. Extension of Medical Benefits

The Government health insurance budget of 1914 contained estimates for the services under the act of referees, consultants and nurses. It is therefore fair to say that, although the war prevented the addition of any of these services, they were contemplated as parts of an adequate plan. It is probable that within the next year the Government will again introduce plans to aid in the provision of hospital beds, consultants' services and perhaps nurses' services. Already one of the approved societies with a membership of over 300,000 gives dental treatment free to the insured.

There is considerable demand in labor circles for the extension of medical benefits to the families of the insured. It is recognized that this would entail a larger contribution, but it would be proportionately less than the amount necessary to protect the men alone.

This demand reaches its logical culmination in the stand of the Labor Party for a national medical service under which medical attendance would be available—much as education now is—for anyone who wanted it. The distinction should be noted, however, between a " state medical service " and a " national medical service." Under the former all doctors would be full time salaried servants of the state. The advocates of such a plan are naturally few. Under the latter the state would rather aim to build up and provide such medical service as was needed to assure the public health; leaving to private, individual and voluntary attention the doctors and patients who did not choose to receive the benefits of the public service, just as now public education is available for all unless the individual chooses to substitute a competent private school.

The Association of Approved Societies, including some of the largest friendly society and trade union approved societies to which belong some six million insured, has also recently come out for nationalizing the medical service in the sense used above as the most satisfactory way of getting medical attention for all with as little red tape as possible.

The doctors as represented by the British Medical Association are opposed to the idea of a national medical service, although they recognize and approve the tendency of the state to provide certain consulting and specialist services in the hospitals on a salary basis as well as for the local authorities to make the medical provisions which they do.[6]

It is, indeed, a fact which no one in England ignores that wholly apart from the insurance, there are today several thousand whole or part time doctors in the salaried employ of one or another governmental body; and the number is constantly increasing. If the insurance doctors are included in this number it would total close to 18,000 doctors.[7] When applications were sought for the thirty referees posts to be filled this summer there were over 1,300 applicants; which certainly indicates no great reluctance on the part of doctors to accept a salaried position with the government.

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[6] The following quotation from an article on "The Future of the Medical Profession" in the *British Medical Journal* for October 19, 1918, indicates quite typically a prevailing view among many thinking doctors as to the types of medical service which they would like to see available:

"What, then, should be the profession's constructive policy? In formulating this it were well shortly to consider the basis, or bases, on which the profession renders service to the community at present, and these services can be classified under four heads, according as they are rendered, under conditions of:

1. Salaried service, whole time or part time—for example, public health appointments, tuberculosis appointments, school medical appointments, etc. (military medical services are not under consideration). These are conditions of "State Medical Service."
2. Part time contract service—for example, national health insurance work.
3. Voluntary service—for example, work done at charitable hospitals.
4. Individual service—for example, private practice. This can be divided into two heads, according as it deals with (a) general work, (b) consultant and specialist work."

[7] "The majority of the medical profession in Great Britain is engaged in either whole-time or part-time service for the state or for local authorities. Of the 24,000 medical practitioners in England and Wales, some 5,000 are engaged as poor-law doctors, some 4,000 or 5,000 in the public health service, possibly 500 in the lunacy service, some 1,300 in the school medical service, and smaller numbers in various other forms of medical service for the state. This is exclusive of the general practitioners who undertake contract work under the National Insurance Act, and who cannot fall far short of three-fourths of the total membership of the profession. It should be noted that many doctors held several appointments."—*Public Health and Insurance,* by Sir Arthur Newsholme, page 83.

There is also an association of about 500 doctors actively in favor of a national medical service.

These facts are dwelt upon at length because this particular problem is significant for America as illustrating how a situation was not fully faced at the outset. Whether Great Britain was to have an **insurance** plan for dealing with health or a **public health program** supplemented by cash benefits, does not appear to have been candidly considered by the initiators of the legislation. As a result, the experiments have conclusively shown **the need for making whatever medical provisions are offered universally available without regard to the industrial status of the citizen, his income limit, or his standing in a scheme of cash subventions.**

In solving this problem serious consideration has to be given to the attitude of the medical profession itself. Its co-operation is manifestly essential to any plan the community decides to undertake. But that co-operation can so easily extend over into dictation that the experience of England is a useful warning. The outstanding features of any plan to be adopted should be offered to the medical profession for an opinion and for suggestion as to ways and means. But **it will be a serious mistake to allow those who are accustomed to think that they "have a vested interest in ill health," to dictate how much or how little medical service the community shall provide for itself on a public and universal basis.** On that matter of fundamental policy which is really the first problem to be faced in working out a plan for health insurance or other public health provisions, **the doctors' advice should not be final,** as they are likely to have a too **ex parte view.** It is true of the doctor's relation to the state, as of the relation of other professional experts, that when basic policies are being determined "the expert should be on tap but not on top."

Contrary to the usual impression in America, however, the doctors are not today opposed to the British act. Quite the opposite is the fact. They realize and state freely that "the doctors are better off under the act than they were before. They have an assured regular income and no bother with collections." As one doctor in a peculiarly influential position said: "The doctors could not be pried loose from the act with a crowbar." Such remarks should not be taken to mean that doctors feel that they have a sinecure under the act. But it has brought a degree of economic independence in the profession, which is unprece-

dented, and has served as a spur to better workmanship and to the enlistment in the profession of more young men and women than the medical schools have ever before had. The fact that the doctors have a small organization which is actually a trade union, and another large and powerful body which is to all intents and purposes a professional union, and that both of these organizations represent the doctors in collective bargaining with the government, should not lead to the conclusion that there is an absence of co-operation in these official relations. This fact does, however, point strikingly to the importance of having groups of officials both in the actual governmental administration and in the local areas **strong enough to carry on the inevitable bargaining process in a way calculated to assure that the rights of the tax payer (that is, everyone) and of the patient are protected.**

In saying that the doctors are today favorable to the act we do not, however, ignore the opposition which exists especially to certain details of the present administration. The greater part of the practitioner's contact with the Government comes through his relations with the local insurance committee (upon which the doctors have of course at least three representatives). And it is inevitably true that varying standards and regulations should be set by these committees. This may give rise to legitimate annoyance as may also the regulations which may be imposed from the office of the central administration in the Ministry of Health. But it would be wrong to think that such regulations are imposed without opportunity for conference. There is a National Advisory Committee upon which the doctors are represented which considers just such matters as these .

Moreover, when all is said, two facts have to be remembered: **Some degree of oversight of the work of the individual doctor is surely in the public interest**; it is only important to be sure that it is an oversight exercised reasonably and tactfully. And, secondly, the English doctor **does not have to become an insurance doctor unless he so elects.** And even when he does, his private practice is still open to him to any extent which his strength enables him to carry it. His panel practice, however, need be as large and no larger than he desires, since he does not have to take an insured person upon his list unless he wishes to. Over 14,000 doctors did not willingly " subjugate themselves to the state " or to the insurance patients, nor would they if the relationship was irksome, continue so to do for eight years. The fact is that once the

arrangement was entered into the doctors did not on the whole find it onerous, unduly inquisitorial or destructive of their freedom. As pointed out in the footnote on page 23, they recognize the need for a variety of types of medical service, all of which should be available both to the public and to the individual doctor who is choosing a congenial type of professional activity.

Medical opposition to the health insurance idea in our own country fastens to some extent on the idea that the "contract" with the Government involves an ignominious, subordinate and undignified relationship of the doctor to the rest of the community. Nothing is further from the truth if the British experience can be taken as proof. It is, of course, true that when this contractual relationship is established many points have to be made explicit which as between the doctor and the private patient have been largely implicit. But to this no conscientious physician can have or in England does have objection. For example, the contract requires that the physician's services shall be available under the following terms:

"A practitioner is required to attend and treat at the places, on the days and at the hours to be arranged to the satisfaction of the Committee, any patient who attends there for that purpose, but he may with the consent of the Committee, which shall not be unreasonably withheld, alter the places, days, or hours of his attendance, or any of them, and shall in that event take such steps as the Committee considers necessary to bring the alteration to the notice of his patients."[8]

In this as in its other provisions it is fair to say that the contract is only laying down for all practitioners **a standard of professional obligation which all good doctors already adhere to.** Indeed, to that extent and in this respect the act has unquestionably leveled up the standard of medical service which is given in England; and to this there can certainly be no honest objection.

In short, the contract is a necessary device for defining the extent to which the Government and the insured patient may call upon the doctor in return for a prescribed sum. That this should lower the dignity of the doctor's status is no more thought of today in England than it would be thought of in any way compromising to professional integrity to take the oaths of allegiance, etc., necessary to becoming an army doctor.

5. Administration of Cash Benefits

The cash benefit is administered through the approved societies, except in the case of the 300,000 "post office contributors," who

[8] Manchester Insurance Committee—Terms of Service for Insurance Practitioners, January 31, 1920.

may collect through the local post offices benefits to the amount of their contributions.

A brief explanation of the machinery will serve to show the part played by these societies. They are the official carriers. A worker must join one of them (or become a deposit contributor at the post office). He then receives from his society a stamp card, which he gives to his employer to stamp as evidence of payment by him of contributions for himself and his employees. These stamp cards, one for each six months, are returned to the worker at the end of the half yearly period; who in turn sends his card to his approved society, which credits him with the payment and presents the cards to the Government as evidence of the collection.

When the worker wants cash benefits he gets his medical certificate of illness from his doctor, and sends it along to the approved society, usually by presenting it locally to an agent, who forwards the claims.

Since the approved societies are organized in different ways— some in local lodges, some in central organizations with merely local agents— the promptness with which claims are settled, the standard of eligibility for benefit, and the thoroughness with which a local visitor investigates each case, in addition to forwarding the doctor's certificates to the central office, vary greatly.

Moreover, since each worker may join any approved society he wishes, it is not unusual to find in one shop workers who belong to from twenty-five to fifty different approved societies. It is the multiplicity of societies which makes it necessary and convenient to use the stamped cards as evidence of payment. And when it comes to payment of benefits, this multiplicity may make it necessary for the agents and sick visitors of a great number of approved societies to be visiting in the course of one day in the same street or even in the same house.

The frightful waste to which this overlapping leads is at once apparent. So important a feature of the act are these approved societies, however, that further discussion of them is postponed to a separate section.

As already intimated, the diversity of standards set up by the approved societies means that some societies are making every effort to curtail payments while others are giving benefits almost without question. The element of control which is counted on by the central governmental authority to keep the payment of benefits within reasonable limits is provided by considering each society's finances

autonomously. The act provides that the surplus of any society (as determined by the government valuation taken every five years) shall be available for increased benefits for the members of that society. These increased benefits may be in the form of either cash or medical benefits. Whether or not this provision has acted as an effectual check upon liberality of payments, is doubtful. For the government, although careful in its inspection, has on the other hand made special and additional financial provisions for societies which become insolvent.

Another provision relating to the control of approved societies' administrative expenses says that if they go above 5 shillings per person per year there shall be an assessment upon the members of that fund or their benefits may be correspondingly reduced.

There has been some criticism on the score of delay in payment of cash benefits. There is undoubtedly some ground for this complaint, although here again much of the criticism can be explained in terms of the disorganized clerical staffs of the approved societies during the war (*e. g.,* one large society lost 100 men clerks the day war was declared). Or, in the second place, delay in settlement is frequently to be explained because of some irregularity in the presentation of the claim for which the approved society is not responsible. Here again the machinery of the stamp cards causes confusion, as for example, when the worker unwittingly gives his card to the agent of a society to which he does not belong and the card is put aside by the agent or lost in the offices of his company.

In general, however, the largest carriers, especially the friendly and big trade union societies, pride themselves upon the efficiency of their office organization and the promptness with which claims are paid. It was the usual thing in a number of the societies visited, to have all the claims received in a morning's mail handled and dispatched the same day. **Testimony is general, however, that the commercial companies which are acting as approved societies are the least satisfactory carriers from the point of view of prompt payment—due perhaps less to intention than to the fact that the health insurance is only incidental to their profit-making business.**

It may be said, in short, that most of the administrative difficulties surrounding the present method of paying cash benefits are not inherent parts of a soundly-organized insurance plan, but they are inherent parts of a method of paying through approved societies

such as England felt compelled to resort to because of the strength of the commercial insurance companies and friendly societies.

6. Administration of Medical Benefits

Because it seemed expedient to work the cash payments through approved societies and because they had available no adequate administrative machinery for the provision of medical treatment, it was necessary for England to set up separate machinery for the administration of medical benefits. The country was therefore divided into about 150 local areas, in each of which an insurance committee was created, the membership of which is representative of the different interested groups. This insurance committee makes the contracts with the local doctors who are to serve in that area. It also decides how many insured persons may be on the list of any one insurance doctor, although a maximum of 3,000 persons has now been set by the Government. This committee, moreover, handles the transfers of insured persons from the list of one doctor to another; receives and deals with complaints against the insurance doctors; makes the payments to the doctors; and makes arrangement with local druggists for the provision of drugs.

The means at the disposal of these committees for dealing with inferior or inadequate medical service are by no means completely satisfactory, but are being constantly improved. The limitations of the size of the panels is universally felt to be desirable, as is also the use of official referees, who will now necessarily work in close conjunction with insurance committees.

Actual formal complaints against insurance doctors by insured persons are remarkably rare, due perhaps rather to the cumbersomeness of the machinery and the difficulty of proving a case, than to the absence of criticism. And it frequently works out in practice that the insured persons complain to the approved society with which they feel on better terms than to the insurance committee; and the approved society then handles the complaint if it is serious. If the insurance committee finds that there are grounds for the complaints which it receives, it may discipline the doctor in any one of several ways, the most drastic of which is to cancel his contract.

In such a case, however, the doctor has the right to appeal to a disinterested local body composed of three medical men and a barrister as chairman.

To safeguard the interests of the insured person who would assure himself of satisfactory medical service, the following methods are provided: He has free choice of doctors; the

chance periodically to change his doctor; and the right to complain to an authority,—the local insurance committee.

In practice, the first provision—free choice of doctors—means today as much, if not more, actual freedom in selection than obtained before the act was passed. For in the great majority of cases those doctors who were already practicing in industrial or agricultural centers became insurance doctors. And in some districts the assurance of a fixed income from insurance practice has meant that additional doctors have been attracted there to practice.

The clamor for " free choice of doctors " was not one, however, which was or is raised by the patients, although it goes without saying that the most successful medical work depends upon a condition of personal confidence between doctor and patient. But there is very much less interest on the part of the insured persons in exercising a free choice than was anticipated. The great problem has, indeed, been to get workers to indicate a preference for some doctor, in order that they may be assigned to a place on that doctor's list. It is a further consideration that the free choice may take place on a capricious basis. Mention was frequently made of cases where a popular doctor on a convenient corner had larger panels than he could handle properly, while better doctors, who were less genial or lived on a side street, had less to do than they could take care of.

Once the insured person is on a given doctor's list and finds the medical service unsatisfactory (even though there may not be sufficient ground for official complaint), he may apply for transfer to the list of another doctor. Such transfer may take place at the end of any six months' period; or, if the original insurance doctor also signs the application, the insured may transfer at once. Manifestly, however, the latter condition is difficult to fulfill; and the former is resorted to in surprisingly few cases.

7. Payment of Doctors

The basis for the payment of doctors is 11 shillings ($2.75) per insured person per year to which in the rural areas are added mileage fees for distances of over two miles to the patients' homes. A doctor with a thousand persons on his list would thus have an **assured income** of about $2,750. (This would mean over $3,000 if considered from the point of view of the comparative purchasing power of money in England and in America) to which would be added his fees for private practice. **It is admitted by doctors and affirmed by all observers that the doctors are thus better off under the act than they ever**

were before. They do not have to worry about collecting fees from panel patients; they get their insurance income at regular intervals of three months; they are virtually guaranteed an income dependent upon the size of the panel. Now that the practice of doctors working in partnership with several colleagues is being extended, the time on duty is being divided up in a way to make the amount of work necessary to earn a comfortable living exceedingly reasonable, leaving time for study and recreation.

Some trouble still arises about the number and identity of insured persons on a doctor's list but difficulties on that score are being reduced. The doctor is paid on the basis of a list made up in advance, and if there are transfers or movement of persons an adjustment is effected at the end of the period. Here again it seems true that doctors are on the whole less particular than they used to be about being sure that the patients whom they treat are on their own panel. If the visitor to a doctor's office needs attention he is likely to get it; or he is sent where he can get it.

The present so-called capitation basis of payment has the effect of making it an object for the doctor to keep his insured patients well and of getting them well as quickly as possible. Of course, there is also possible the view that since the fee is assured the service will not be so good. Undoubtedly, instances to illustrate both tendencies could be cited. But on the whole it is agreed that the capitation basis is the most satisfactory.

In Manchester and Salford, the doctors originally objected to the capitation plan and a basis of payment for services rendered was adopted. A similar plan started in four other localities has been dropped. The plan provides a scale of fees for different types of visit and a full record by the insurance doctor of services rendered by him. The records pass through the hands of a committee of doctors to see that there has not been excessive visitation and the payments are then made. The total fund from which payment comes, however, is determined on the capitation basis; that is, it is as many times 11 shillings as there are insured persons in the entire district; so that no doctor gets more in the long run than he would in any other district—unless he happens to be working in an area where the rate of sickness is constantly excessive. Since the total resources are thus limited, it has thus far under the visitation basis been necessary at every settlement to discount the doctors' claims for remuneration. The result naturally is that the good doctors who find their bills discounted because their colleagues have

been doing too much visiting and are thus making large claims, inquire into the type of medical service being rendered. Whether the reason for this discounting of claims is that the scale of fees for the several services is high or that the doctors do too much visiting, it is impossible to say. The doctors themselves, however, and others in the Manchester district, believe in the system and say that it works to satisfaction. It has the good result, they contend, of paying for work done and thus encouraging good work where it is needed. Not the size of the panel, but the rate of sickness should in this view determine the payment.

The capitation basis, however, is clearly the simpler of the two; requiring less check and oversight, and giving the benefit of a guaranteed amount of income and of freedom to give all the medical attention necessary without thought of seeming to "overvisit." And in the last analysis the kind of medical attendance given is determined more by the education and morale of the profession than by the method of compensation.

The English experience in administering medical benefits thus confirms the case for (1) local administration of the medical service; (2) for a uniform basis for contracts with the local doctors in all districts; (3) for a uniform basis for certification as to physical condition justifying cash benefits; (4) for medical referees; (5) for co-operative use of local diagnostic clinics.

8. Drugs

A prescribed number of drugs and medical appliances are available free on prescription from the insurance doctor. These prescriptions when filled are forwarded to the insurance committees who make the payments to the local chemists whom they have appointed to fill the insurance prescriptions, on the basis of charges which have been agreed to between the Government and the national pharmaceutical organization.

In the event that a doctor is found to be giving too many prescriptions or those calling for too expensive drugs for which equally good but cheaper substitutes are available, he may be brought before a committee of doctors to explain his conduct.

In practice, however, the administration of the drug provisions of the act gives rise to little difficulty and is considered to be running smoothly. Criticism under this head—as with the other features of the act—fastens rather upon the small number of items and appliances made freely available to the insured as their statutory right.

9. Approved Societies

The use of the approved societies as carriers of the cash benefits has been an expedient but in many ways unfortunate procedure. **Certainly no other country seeing the extra expense, duplication and over-lapping caused by the present system should think of resorting to this method of handling the cash benefits.**

There are now over 900 approved societies and there were at one time over 2,000, many of which have been consolidated with other funds.

Each society, of course, has its own central office, its own local agents and sick visitors. Accounts must be kept for it separately in the Government offices and there must be individual supervision of their activities. Some societies select their risks; others admit every applicant. There is comparatively little segregation of risks by occupation and no segregation by residence. The statistics which would show the incidence of sickness by occupation and locality are thus especially difficult to get.

In short, the whole approved society machinery is a fine example of what to avoid.

Indeed, there are not lacking signs that the English themselves would be glad to be rid of them and to administer the insurance through one national fund. The valuation of approved societies which is now nearing completion will undoubtedly reveal wide differences in the amount of surplus which will be available for increased benefits in the several societies. If it comes about that some of the strongest commercial companies and friendly societies are in a position to offer larger benefits than many of the other societies, there will undoubtedly be considerable objection from the trade unions. And it is openly hinted even in official quarters that in the event of such a wide discrepancy being revealed, the agitation for one national fund as the carrier would be very active.

Certainly the warning was again and again repeated to us: "If you go in for health insurance, don't have anything to do with approved societies."

10. Hospitals

As already stated, no hospital treatment is given under the act. The doctor who wants his patient to have institutional care must get him into a voluntary hospital. Of late years this has been increasingly difficult because of a shortage of beds and now also because the hospitals are financially embarrassed. Costs have more

than doubled, former contributors are now taxed so heavily that they do not give; contributors from among the "new rich" have not yet materialized. As one advocate of privately supported hospitals naively remarked to us: "We expect that in another ten or twelve years the new rich will get the habit of giving and then the hospitals will be all right."

But meanwhile frantic efforts are being made to keep the hospital doors open at all; and those who are planning the public health program of the country, see that a wholly new way of meeting the problem is essential. It is possible that the Government will in the near future abolish the poor law hospitals and make their beds available for use by the local authorities. It is also possible that the Government will subsidize the hospitals on the basis of the number of beds used by insured patients. If some such arrangements as this are made, it will be then necessary to take steps to pay the hospital doctors who now give their services; as it is clear and right that if the hospitals are to be paid for their work for the insured, the consultants should be paid also.

This is an admittedly transitional time in respect to hospital provisions, and those who are anxious to see adequate provision made as soon as possible with no suggestion of charity about it, are advocating that the hospitals be operated as public institutions. This will undoubtedly come in time, although the Minister of Health has officially stated that this is not the present Government program. Nevertheless the trend is already toward wholly publicly supported institutions for tuberculosis and maternity; and a good number of municipalities have their own general hospitals.

At the end of August of this year (1920), the Minister of Health introduced a bill which is likely to become a law, which aims to make a beginning at public support and control of the hospitals. The proposed legislation gives power to county authorities to supply and maintain hospitals, to contribute to hospitals, to undertake the maintenance of any poor law hospitals in their areas, to provide ambulance service. It also gives these authorities power to raise the necessary funds.

The element of national control begins to enter, for contributions out of county funds to voluntary agencies are only allowed "on such terms and conditions as may be approved by the Minister."

This legislation is obviously a temporary and temporizing manner of dealing with the shortage of hospitals, since it puts the whole financial burden on the counties while making possible a beginning of national oversight. Still further legislation from the national

point of view is thus needed, and is probably contemplated in connection with a bill to transform the poor law institutions into general municipal agencies.

11. Tuberculosis

At present provision is made under the act for the sanatorium treatment of insured persons having tuberculosis. This arrangement will be discontinued after the year 1920, not because it is no longer needed, but because it is felt that the local authorities can handle this disease better and more adequately. For then the whole population will be considered at once from the point of view of institutional care of tuberculosis, rather than be treated in two groups—the insured and the non-insured. Domiciliary treatment for this disease remains, however, the duty of the insurance doctor.

Admittedly the present provisions are too few; almost every insurance committe has a waiting list for sanatorium treatment. To pass on to the local authorities the work of maintaining all the sanatorium beds necessary for tuberculosis will, therefore, not solve the problem. As was said above with relation to general hospitals, it will be necessary in the immediate future for the Ministry of Health in conjunction with the local authorities, to adopt a policy which will really promise to cope with this enormous problem.

Interesting experiments are being made in the organizing of self-supporting farm colonies for tuberculosis patients who have had sanatorium treatment but who will be much safer and healthier if they do not immediately return to the cities. One of these colonies just out of Cambridge in Cambridgeshire may be mentioned as deserving additional study at the hands of those in this country who are carrying on the community's attack on this scourge.

12. Nursing

No nursing services are provided under the act although as already pointed out they were contemplated in 1914; and will in all probability sooner or later be added. The nursing situation, like that of the hospitals, is admittedly unsatisfactory and in a transitional state.

Nursing services are now provided by "local authorities in connection with Tuberculosis and Infant Welfare, by Parish Councils for the supervision of children under the Children Act, by Education Authorities in following up the recommendations as to treatment made by School Medical Officers, and by various voluntary agencies. With such a plethora of authorities it is to be expected

that it will frequently occur that two or more nurses will at one and the same time be visiting the same family."[9]

It will thus be seen that some districts are adequately staffed while others are not; and that there is needed a proper coordination of national and local policies which will make universally available in a public way the services needed.

13. Prevention and Research

The claim that health insurance means a new awareness of the value of preventive medicine has on the whole been substantiated in the experience of Great Britain, although the developments have perhaps been in unforeseen directions.

It may be fairly said that the Ministry of Health which was created in 1919 grew not only out of a knowledge of the need for co-ordination of medical efforts, but also out of the fact that a unified national health program and administration **was shown to be necessary to national vitality by the health insurance and by the army draft.**

It is also true that since the insurance act was passed, measures have been adopted for providing separately for venereal disease, for tuberculosis, for maternity and child welfare. How much of a causal relation exists between the needs revealed by the insurance act and the inception of these services, it is impossible to say. **But it is certain that, now health insurance is a fact, there is a new impetus and eagerness to attack the hospital, nursing, dental and sanatorium problems on a public and fundamental basis.** It is also true that the demand for a constructive policy worked out under a national medical service is greater than it would have been today had there been no insurance act. And the doctors have certainly come a long way toward their new attitude regarding preventive medicine, toward clinical co-operation and toward regarding themselves as custodians of the health of the community as well as the curers of its ills. This change of outlook, this invaluable educational process, can be ascribed almost wholly to the experience they have gained in working the insurance act.

It is, moreover, now widely realized that the tuberculosis as well as other sickness cannot be greatly reduced until the housing problem of the country is seriously faced on a large scale.

It was to have been expected, however, that the records of sickness would reveal local problems and occupational exposures which needed special attention. Medical records were required of

[9] A Public Medical Service, by David McKail and William Jones.

the insurance doctors until the war when they were abandoned, and only at the present time is attention being given to devising a record card that will be of value. For it is admitted by all that the pre-war records were practically valueless as disclosing the incidence and nature of the country's sickness.

In short, after eight years of the insurance act, there is not a definite body of knowledge as to which localities, trades or age groups experience which particular kinds of illness. But here again, extraordinary as this omission seems, it must be remembered that through five war years the doctors who remained in civil life hardly had time to see all the patients who needed attendance to say nothing of trying to keep individual records.

On the side of research the results, although only indirectly attributable to the health insurance, have been most valuable. A Medical Research Committee was organized at an early date after the act was passed; and during the war that committee became the official research body of the Government under which worked the Health of Munitions Workers' Committee and others. Its findings, reported in full in special monographs and in its very interesting annual reports, have been of great medical value; and the chief problem, as was pointed out by the secretary of the Committee, is to get the information obtained by research quickly into the hands of all the general practitioners of the land.

So important has become the work of this Committee that it has now become the Medical Research Council, removed from under the jurisdiction of the Ministry of Health (for reasons which seem to the outsider hardly sufficient), and placed directly under the Privy Council.

On the whole, considering the intervening problems, **the work of fostering preventive measures and research has gone well**; although it is a matter of great regret that the original form of medical record keeping was not well enough designed to be of permanent use, and that the body of existent records is so meager.

Not the least significant of the preventive influences which have been set in motion are two reports, one by Sir George Newman, Chief Medical Officer of the Ministry of Health, on "An Outline of the Practice of Preventive Medicine;"[10] the other the Interim Report of the Consultative Council on Medical and Allied Services on the "Future Provisions of Medical and Allied Services."[11]

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[10]Cmd., 363.

[11]Cmd., 693. This, and the report referred to in footnote 10, may be ordered by the code numbers given at a nominal cost from H. M. Stationery Office, Imperial House, Kingsway, London, W. C. 2.

These reports have had a wide reading and are in harmony on their major recommendation, although the latter carries its constructive proposals into greater detail. They emphasize the strategic place in a national public health program of:

1. The general practitioner as the first and major point of contact with the people;
2. The primary (or local) health center as the unit of local medical work especially on its diagnostic and specialist side although the members of the clinic would be largely local general practitioners;
3. The secondary (or district) health center with salaried specialists and consultants having necessary hospitals and laboratories;
4. A number of supplementary services and special hospitals;
5. A better integration of medical education with the day-by-day work of the general practitioner.

Their conclusions as to general principles and as to methods of carrying them into practical effect seem to your investigators to be sound and to warrant the further study of your Commission. Two copies of each accompany this report.

14. Insurance Finances

The sources of **income** for the insurance expenses are the following:

1. Contributions of employers and employed.
2. Contributions of the State under the act.
3. Supplementary Grants of Parliament for Women's Equalization Fund; and for the Central Fund.
4. Parliamentary Grants as follows:
    a. Medical Grants in Aid (under Act of 1913).
    b. Special Grants in Ministry of Health Budget for Central Administration.
    c. Special Grants for Expenses of Insurance Committee.

The sources of **expenses** under the insurance act are as follows:

1. Cash Benefits.
2. Doctors' Fees.
3. Administration Expenses of
    a. Approved Societies.
    b. Insurance Committees.
    c. Central Administration.
4. Drug Fund
5. The Reserve Fund
6. The Contingencies Fund.
7. Women's Equalization Fund.
8. Central Fund.

In explanation of the above two paragraphs it will be useful to describe those funds not already explained.

The Reserve Fund is set up to enable the insurance fund to pay for the sickness of the older members. The statutory contributions are based on the sickness rate of 16 years of age and until there has been one complete generation contributing under the act it is necessary to create a reserve to meet the increased incidence of sickness of the older members admitted at the start. The fund is based on a complete payment by 1950.

The Contingencies Fund is created for every approved society to meet any extraordinary demands that might arise.

The Women's Equalization Fund is to pay for the high incidence of sickness of married women workers, which the societies have found it necessary to provide for.

The Central Fund is to provide for those cases where an approved society shows a heavy and extraordinary deficit.

The moneys available from each contribution are divided as follows for men:

	Pence	
Sickness Benefit	3.02	(per cap. per week)
Disablement Benefit	1.11	
Maternity Benefit	.68	
Medical Benefit	1.92	
Expenses of Administration	.94	
Total	7.67—7 2/3	pence.
To Benefit Fund (including administration)	7-2/3	
To Contingencies Fund and Central Fund	2/3	
To Redemption of Reserve Fund Value	1-2/3	

10d.—total of employer and employees' contribution.

But the expenses under the act, in addition to requiring 2/9 of the expense of benefits to be borne by the state, necessitate other appropriations.

The increased doctors' fee now makes necessary a special Exchequer grant. The amount of this grant in 1919 was £3,000,000; but the 1920 figure will be considerably higher.

The Women's Equalization Fund comes from an Exchequer grant of £280,000.

The expenses of administration in the Ministry of Health come (as far as can be roughly estimated from the 1920-21 budgets) to something over £400,000.

The statement given below will indicate **in an approximate way only** the aggregate sums involved in the insurance plan for the year 1920.

Approximate Balance Sheet of Receipts and Expenditures for the Operation of the Act (1920)[12]

Receipts		*Expenses*	
Contributions of Employers and Employees	£29,800,000	Benefits (cash and medical)	£28,700,000
State Grant including Supplementary Grants on Women's Equalization	6,900,000	Supplementary Medical (1919 basis)	3,100,000
		Central Administration	400,000
		Contingencies Fund	1,800,000
		Reserve Values	1,500,000
		Reserve Surplus	6,000,000
Supplementary Grant for Medical Services (1919 basis)	3,100,000		
Interest on Cash Reserves	2,000,000		
	£41,800,000		£41,500,000

A rough check of this balance sheet is obtained by making a comparative study of the Estimates of 1920. These show that the expense of the act *to the Government* and payable out of the exchequer is between eleven and twelve million pounds for the year. Such an amount added to the receipts of the act from the contributors roughly balances the total expense of the act.

Another sidelight on the cost of the act was supplied by the figures of Dr. Addison, the Minister of Health, in reply to a question in Parliament on July 19, 1920. He said that since the inception of the act the total cost was in round numbers 190 million pounds. Of this amount 99 million pounds had gone in benefits; expenses and administration had taken 25 millions; and there was a balance in reserve of 60 millions.

About 12 per cent, he said, of the receipts from contributions went to the approved societies for their expenses of administration.

As far as it is safe to draw any conclusions from the above figures, they indicate that to provide medical service for about 15 million people and cash benefits to the amount of something over 15 million pounds, the yearly Government expenditures is about 12 million pounds and the cash contributions of employer

[12] This statement aims to give only the *most general approximation* of receipts and expenses. It includes a figure for the supplementary medical grant which is probably much too low owing to the fact that the 1920 medical payment is at the new rate of $2.75 per insured.

and the workers are something over 29 million pounds. And it has so far cost one pound for administration for every four pounds expended on benefits.

It would seem to be fair to draw the conclusion that for the benefit of 15 million peoples' health, about 205 million dollars (in terms of American currency) per year is being spent; or between $13 and $14 per insured person per year. If these figures are at all accurate, the total outlay appears large for the benefits received.

In a careful study of "A Public Medical Service" (Allen & Unwin), 1919, made by a Glasgow doctor and the Clerk of the Glasgow Insurance Committee, the case is set forth with a convincing show of accurate statistics for a truly public medical service (cash benefits excepted), which would cost between 12 and 13 shillings per person per year—or a little over $3. The additional cost necessary to pay cash insurance claims would certainly not amount to over $5 (probably $4 would be much more nearly a correct figure on the basis of the amount of the English benefits); making a total cost of less than $10 per capita for medical and institutional treatment available for the entire population with the addition of cash benefits of the amount specified in the British act.

These figures are introduced as being in no sense exact or conclusive. But they are believed to indicate that the present methods of an insurance scheme with duplicating approved societies, elaborate doctors' panels, government inspecting agencies and small-scale private druggists, create a variety of channels for small wastes and leakages, which in the aggregate amount to an unwarrantedly high expense for the value received.

Moreover, it is obvious that the method of financing the measure has now departed (if indeed it ever was so financed) from an insurance basis. Special funds are created and new costs are added with no regard to the amounts originally made available. This is not said in objection to the present method of financing by supplementary grants. But it is a further point in the evidence that **the tendency is increasingly away from an insurance and toward a public health basis of finance, so that the funds are made available on a basis of public need rather than solely on a basis of joint contribution and a pooled risk.**

V. Conclusions

THE general conclusions reached by your investigators were somewhat summarily stated at the outset. But it may not be out of place to consider finally some of the more specific results of the British experience from which America might especially profit.

A. The application of the insurance method to the provisions of medical, hospital and nursing facilities is a clumsy and indirect way of making sure that the public health is being fostered and conserved.

The tendency is a wise one which brings a separation between the medical services which should be universally available and the cash benefits which might remain on an insurance basis.

On the other hand, it is undoubtedly true that the immediate expense to the public treasury can be kept considerably reduced by securing payment for the medical services out of the fund created by the joint contributions.

And it is further true, not only in England but wherever health insurance has been instituted, that the working of the insurance has supplied the great education to all groups in the community but especially to the doctors, as to the necessity for a more extensive public health program.

Hence, as a practical matter, the incorporation of the medical benefits into the insurance act is probably a wise step coupled with which should be the extension of these benefits under the act to all dependents.

B. The public health provisions of the community should as soon as possible include the following:

Medical attendance for all sick members of the community who desire it (including general practitioner and consultant services):

Institutional treatment including hospitals, sanataria and convalescent homes;

Medicine and medical appliances;

Dental treatment, nursing; and

All medical services incident to maternity.

These provisions should be available on a basis of joint state and local support with the actual administration of the work as the responsibility of the local health authorities, who would be so organized or reorganized as to be able to include the above services under their care.

Plans for the relation of local to district medical facilities have been admirably worked out in one or two English counties and their method of organization suggests a model for careful consideration.

As illustrative of the method there in use, the plan given below [13] is valuable:

1. The authority for carrying out the scheme will be a Board consisting of representatives of the County Council and of the General Hospitals.

2. The General Hospital areas shall be those shown on the sketch plan, subject to such modifications as experience shall show to be necessary.

3. In each Hospital area an Advisory Committee shall be formed of members of the Hospital Staff and Medical Officers in charge of the out-stations, whose duties will embrace—

a. Ensuring that all treatment given at the out-stations is effective, and

b. Advising the Board of Representatives on all medical matters, including all difficulties arising in connection therewith.

4. The situation of the out-stations shall be as shown on the plan and where practicable shall be established in connection with the Cottage Hospitals. They will be opened in the order decided by the amount of work likely to be done at each and will be arranged to meet the circumstances of each particular area, being larger and more completely equipped in the denser localities than in the more scattered areas.

5. The out-stations will be provided and equipped by the County Council.

6. The uses of the out-stations are primarily for examination and out-patient treatment in connection with—

a. Venereal Diseases,
b. Tuberculosis,
c. Ex-service Men,
d. School Children,
e. Maternity and Child Welfare,

for which provision has been made at the public expense. They will also be available for other conditions for which provision may be made in the future, and may be used by the Medical Officers for insured persons and general hospital cases, by arrangements with the County Council.

7. The Staff will be—

a. *Medical*

(1) A regular staff consisting of local practitioners appointed as medical officers by the Board of Representatives.

(2) A consultant staff consisting of—

(a) Visiting Staff of the General Hospital.

(b) The Tuberculosis and Venereal Disease Officer of the County Council.

b. *Nursing*

(1) District Nurse

[13] Report of County Medical Officer on Health to Gloucestershire County Council, June 4, 1919.

(2) Masseur and Masseuse
(3) V. D. Orderly and Nurse } peripatetic

8. The Out-stations will be opened—

a. Weekly at a convenient hour, on a fixed day, for attendance by the medical officer, or oftener if necessary for the work of the County Council.

b. Periodically, for attention by members of the Visiting Staff, and by the Tuberculosis and Venereal Disease Officer, by arrangement.

c. As often as may be necessary for intermediate treatment by the Nursing Staff.

d. At such other times for the convenience of the Medical Officer in seeing his own patients and hospital cases, by arrangement with the County Council.

9. A register shall be kept of all attendance in a book provided for the purpose, and a case file kept for each case containing such simple notes as may be necessary for the medical history of the patient.

It should be pointed out that such proposals as these do not involve the idea of a universally state-employed medical service. Your investigators believe that the idea of such a service is repugnant to the great majority of physicians and patients, and that the best results, at least for some time to come, are obtainable in other ways. For example, the general practitioner who is to be available to give public medical service to any comer, would (as now) go upon the Government's list and have assigned to his care those families who elected to have him as their physician. He would then be paid on a capitation basis. If any individual feels that he would get better service by going to a doctor who is not on the public list, or by paying a public practitioner in his other capacity as a private doctor for the service he gets, he is at liberty to elect either of these alternatives. And the doctor meanwhile has whatever spur is provided both by the opportunity of getting on in the public service or of making good in private practice.

In short, there would be necessary the employment on full or part time (as at present with the insurance doctors) by the public health authorities of a constantly increasing number of general practitioners and specialists, thus accelerating an existent tendency. **But there would still be the widest possible latitude for those persons who chose to secure their own medical and institutional care, and for those doctors who preferred on whole or part time, to carry on private practice.**

Moreover, the existence side by side of a considerable amount of both public and private practice would undoubtedly react wholesomely on each, keeping initiative, energy, professional ambition and a spirit of public service alive and growing.

In short, **the medical benefits under an act should be as liberal as possible, including the maximum of institutional provisions as well as general practictioners' care,** and all treatment should be carefully co-ordinated to bring into effective use for the insured and his dependents all local and all state facilities.

C. Having made medical provision available for all insured and their dependents, it would still be necessary to make provision on a compulsory insurance basis for payment of cash benefits to workers when they are unable to work and secure wages.

All employed persons should be required **to insure in a state fund** out of which cash benefits would be paid during incapacity due to illness.

D. Cash benefits should be at least 50 per cent of wages.

E. The administration of cash benefits should be decentralized on the disbursement side on a geographical basis, but centralized on the collection side, so that the Fund would be pooled and the risk distributed over an entire state. Benefits should be paid through a local agency, which would be in the control of representatives of the affected groups.

F. The cash maternity benefit should not be administered on an insurance basis, but should be universally available and should be of an amount to cover fully the expenses of confinement. There is much to be said for a policy which makes of this benefit a maternity endowment of an even more substantial amount.

Medical service should be freely available for all maternity cases.

◇

It is recognized that these conclusions may seem to your Commission to extend into a larger field than that of the immediate inquiry. They are, however, the conclusions to which your investigators were led in an honest and wholly unprejudiced effort to discover the good and the bad in the English act, from the point of view of its furtherance of the public health and from the point of view of its availability for American uses.

It may, of course, be necessary for each separate community to make the same social experiments and learn by the same mistakes. It is to be hoped, however, that this is not true; that it is possible for one community to build upon the experience of another. And the experience proves, as your investigators read the evidence, that the acute necessity for greatly developing the public medical facilities of the state should be recognized, and set apart from and in addition to any insurance provisions. **The two are not mutually exclusive. They are supplementary.** But

the proper and wise development of the public health services will and should modify the kind of insurance plan which is adopted.

Your investigators recognize fully the painful fact that those forces which have for various reasons been in opposition to the introduction of health insurance into America, have taken the line that "prevention" rather than insurance is the method to pursue. Where this position was simply taken to delay matters and "preventive" was simply a plausible cant phrase with which to oppose any governmental action, the opposition has of course been sinister to a degree.

But this fact should, nevertheless, not be allowed to lead to a slighting of the immediate value and need of aggressively preventive work. Hence, if we are to meet that opposition most effectively we might well take up the slogan:

> **Medical and institutional service freely available for all employed persons and for their families, with cash benefits for physically incapacitated workers out of a fund created by joint contributions, and with the strengthening and co-ordinating of the federal, state and local public health activities on behalf of children, mothers, the subnormal and abnormal, the aged and those suffering from all infectious diseases.**

It is not a question of prevention or insurance. It is—when all elements in the problem are faced at once—a question of assuring simultaneously adequate medical service, prevention and cash subvention. And there is no good reason why these three aspects of a public program should not be developed together. Certainly to allow the advocacy of one to be used as a basis for opposition to another is unscientific and short-sighted.

This report will certainly be construed wrongly if it is taken to be unfavorable to health insurance in general or to the British act in particular. It aims rather to give a discriminating statement of the extent to which insurance has been able to carry out the original promises and purposes of its proponents.

The British Health Insurance Act has been a distinctly forward step in social legislation. It is, however, to be hoped that your Commission will see its way clear to favoring a program at once more thorough-going, far-reaching, economical and scientific, which will, however, include an application of the insurance idea in its legitimate sphere.

Appendix

Persons Interviewed in Course of Inquiry into British Health Insurance

Mr. W. A. Appleton, secretary, General Federation of Trades Unions; Mr. John Baker, secretary, Iron & Steel Trades Confederation; Mr. Barlow, assistant secretary, Workers' Union; Dr. Ethel Bentham, panel doctor, London, Member Labour Party Committee on Public Health; Mr. George P. Blizard, insurance expert (former secretary, Labour Party Committee on Public Health); Miss Margaret G. Bondfield, secretary, National Federation of Women Workers; Mr. G. A. Stuart-Bunning, secretary, National Federation of Sub-Post Masters; Mr. G. W. Cantor, insurance executive of Union of Post Office Workers; Mr. A. S. Cole, Peek, Frean & Co., Ltd., London; Dr. Alfred Cox, secretary, British Medical Association; Mr. Wm. Cramp, assistant secretary, National Union of Railwaymen; Mr. G. W. P. Epps, Government Actuary's Office; Dr. Letitia D. Fairfield, medical officer of London County Council; Sir Walter M. Fletcher, secretary, Medical Research Council; Mr. Thomas Foster, building trades employer, Bromley, Lancashire; Mr. I. G. Gibbon, administrative official in Ministry of Health; Mr. E. Hackforth, administrative official in Ministry of Health; Mr. R. W. Harris, administrative official in Ministry of Health; Mr. Frank Hodges, secretary, Miners' Federation of Great Britain; Mr. D. J. Jenkins, insurance executive, Iron & Steel Workers, Approved Society; secretary, Association of Approved Societies; Miss Eleanor T. Kelly, employment manager, Debenham & Co.; Dr. Wm. Kerr, medical officer of London County Council; Mr. F. Kershaw, insurance executive, National Federation of Women Workers; Mr. James P. Lewis, executive officer, Hearts of Oak Benefit Society; Mr. E. J. Lidbetter, Bethnal Green Poor Law Union; Mr. Thomas Lilly, clerk, Manchester Insurance Committee; Mr. McFarlane, divisional inspector, National Health Insurance, Manchester District; Sir Charles Macara, cotton manufacturer, Manchester; Mr. A. B. Maclachlan, administrative official in Ministry of Health; Mr. J. S. Middleton, assistant secretary, British Labour Party; Mr. Miller, insurance executive, Workers' Union; Miss Murby, inspecting staff, National Health Insurance; Sir Thomas Neill, president, National Amalgamated Approved Society; Dr. Charles A. Parker, consulting physician; Dr. Marian Phillips, women's organizer of Labour Party; Mr. Charles G. Renold, firm of Hans Renold & Co., Manchester; Dr. Harry Roberts, panel doctor, London; Dr. Meredith Roberts, administrative official in Ministry of Health; Mr. D. A. Rushton, editor, *National Insurance Gazette;* Mr. Samuel Sanderson, secretary, Insurance Section, Amalgamated Association Card, Blowing and Ring Room Operatives; Mr. Sharp, Harrods' Department Store, London; Mr. Robert Smith, insurance executive, Cooperative Wholesale Society Approved Society; Mr. H. O. Stutchbury, administrative official in Ministry of Health; Mr. Fred Thomas, Amalgamated Weavers' Association; Mr. John Turner, secretary, National Amalgamated Union of Shop Assistants; Miss Ward, inspecting staff, National Health Insurance Dept.; Mr. Warren, insurance executive, National Amalgamated Union of Shop Assistants; Sir Alfred W. Watson, government actuary; Mr. & Mrs. Sidney Webb, economists, members 1909 Poor Law Commission; Dr. A. Welpley, secretary, Medico-Political Union; Dr. J. S. Whitaker, administrative official in Ministry of Health; Mr. H. L. Woolcombe, secretary, London Charity Organization Society.